

# SBGH OBSTETRICS SERVICE HANDBOOK

## Welcome to SBGH Obstetrics!

This is intended as a guide to understand your role while on the Obstetrics service at St Boniface Hospital. It will also serve as a basic resource for many of the day-to-day activities that you will encounter over your rotation. If you have any questions or concerns, please let one of the Residents know. We are here to help and to make this a fun and useful experience.

1. **The Obstetrics service includes:**
  - 3<sup>rd</sup> floor: High Risk L&D and LDRP (low-risk), Triage
  - 3A: Postpartum
  - 3B: Antepartum
2. **General service information:**
  - The dress code is scrubs which may be found on the High Risk L&D unit. Ask for the code to get in.
  - Rounds start at 7:30am sharp Monday-Friday in the Meeting Room behind the nursing desk on LDRP
  - Rounds start at 8:30am sharp on weekends/holidays (same location)
3. **You will be assigned to cover one of the following three areas each day: Triage, LDRP/Labour Floor or wards (3A and 3B). Please ensure that your name and pager # is on the board where you have been assigned.**

**4. Clerk signature cards:**

- You will be given cards at the beginning of your rotation to keep track of your clinical experiences.
- Do not panic! There are plenty of deliveries to go around. However, if you are worried about meeting your required objectives, please notify one of your Residents.
- Once your card is full, you are still expected to participate on the labour floor and in Triage. This is not an invitation to sleep all night on call. The Residents will give feedback for your evaluation if you choose to make yourself absent on call or during the day.

**5. Your role on LDRP/Labour Floor:**

- If you have been assigned to this area, you are expected to sign up for deliveries by writing your initials on the labour board.
- Introduce yourself to the patient and to the patient's nurse
- You are expected to round on your patient regularly throughout the day and write a note in her chart to document her progress
- There are also elective c/s scheduled during the week. If you are interested in participating, you can check the book on LA2 to find out when these will be taking place and sign up to scrub in

**6. Your role in Triage (see section below on triage visits):**

- Triage operates like a mini "ER" for pregnant patients
- You are to assess patients, perform supervised exams where necessary and discuss your patient with the Resident or Attending

**7. Antepartum clinics**

- All housestaff are required to attend clinics in the ACF Women's Clinic *except if you are postcall*
- If you get called for a delivery, you may leave clinic to attend
- If you have scheduled teaching, inform the Attending running the clinic and you will be excused
- Clinic times are as follows:
  - Dr. McCarthy Thurs 1-4 pm

**8. Mandatory weekly rounds (you must attend if post-call)**

- Grand Rounds every Wednesday 7:45am (Nursing Building NG002, Link Room)
- High Risk Rounds every Friday 8am (Rm AG002-1 South Dining Room)

**9. Additional teaching sessions**

- Tuesday 8-9am Gyne Onc Teaching (2<sup>nd</sup> floor library)

**10. On-call responsibilities**

- You are expected to sign-up for deliveries, help assess Triage patients and take calls from the wards
- The on-call clerks/interns are also expected to round on all post-op cesarean section patients the next morning *before* meeting for Rounds at 7:30am (or 8:30am on weekend). A list of these patients can be found on WRS3.
- If it is quiet on the labour floor/triage at night, we encourage you to take some time to rest but you should try to make an appearance every so often to check if anything needs to be done, if there are new labouring patients, etc.

## Management Decisions for Patients:

### *Ward Patients*

1. Monday – Friday from 8:00-17:00, please call the attending that the patient is admitted under (after discussion with Senior Resident). If no response call the on-call group.
2. After 17:00 and on weekends, please call the on-call group for the patient's primary physician.

### *Labouring and Triage Patients*

Review with the Resident on call or if you are comfortable with your plan review with attending on call for the patient's primary physician

## The Basic Obstetrical Triage Visit

Unlike our Internal Medicine counterparts, our intention on the Obstetrics service is not to illicit a detailed history from conception to present times, including the medical history of the patient's cousin twice-removed. Rather, the attention is on a "focused history and physical exam" (think Emergency department). There's a reason why there isn't a lot of space to write. Your goals should be to three-fold:

- 1- To gather pertinent information based on the entrance complaint.
- 2- To devise a differential diagnosis, select *appropriate* investigations and decide on a management plan.
- 3- To present all of the above information in a concise manner to either your Senior Resident or to the Attending.

This is intended as a rough how-to guide for structuring your triage note to ensure all relevant information has been included. You will then be able to impress your residents and attending staff.

Your first sentence should look something like the following (you should get into the habit of including Rh and GBS status here also. Also get into the habit of confirming dates, use the LNMP if that is all that is available; otherwise, use the EARLIEST ultrasound done to wheel out the EDC):

\_\_\_ yr old G\_\_P\_\_ at \_\_\_ wks GA Rh +/-/? GBS +/-/?  
Known GDM on diet-control and gestational hypertension on labetolol

(This is also a good place to summarize any known issues in the current pregnancy or really important details specific to the case)

**HPI:** This part should focus on 3 areas

- 1- All entrance complaints/symptoms. Common ones we see in triage are bleeding, cramping, abdominal pain, leaking fluid/discharge, and decreased fetal movement. You need to elaborate on each of these.
- 2- Obstetrical symptoms. Always ask these 4 questions if not offered by the patient: Any bleeding? Any cramping? Any leaking? Any fetal movements? This would also include questions pertinent to known conditions in pregnancy. For gestational HTN ask about 4 specific symptoms: headaches, visual changes, change in edema, RUQ/epigastric pain. For GDM/DM2: you might ask about the patient's general sugar control.
- 3- General review of systems. Ask quickly about symptoms head-to-toe (headaches, SOB, CP, fever, chills, urinary/bowel symptoms, etc). Also ask in general if there have been any issues/problems in the current pregnancy, whether ultrasounds/fetal assessments have been done for any reasons.

**PObHx:** Quickly ask about outcomes of other pregnancies including mode of delivery, GA at delivery, pregnancy complications, etc. This should be concise as well.

Eg. 2001 SVD at 35 weeks (induced for PIH)  
2003 CS at 39 wks for fetal distress

**PMHx/PSurgHx:**

**Meds:**

**Allergies:**

**Social Hx:** if relevant

**O/E:** This again should be a focused exam. For example, if there are no neurological symptoms, do not waste your time doing the CNS exam. However, if your patient is being seen for elevated BP, then reflexes and clonus should be checked. Again remember that in Obstetrics, there are 2 patients involve, the mother and the fetus. So we need to "examine" *both*.

**Abdo:** this will be relevant if any kind of pain/cramping is a complaint. Also allows for Leopold's manoeuvres to be done to assess for fetal lie (cephalic, breech, transverse). Symphysis fundal height (SFH) could also be measured, especially if the patient has had poor prenatal care. Remember to check for CVA tenderness as pyelonephritis is fairly common in pregnancy.

**Sterile Speculum exam:** You should do this with the help of a Resident at first until you are comfortable doing the exams, as well as for any patient < 37 weeks. This should be carried out to assess for:

1. any kind of bleeding (especially if there is no previous US report indicating the location of the pregnancy)
2. any kind of leaking or discharge (check for pooling, nitrazine test and ferning)
3. assess for cervical dilatation in any patient in which a vaginal exam is contraindicated (placenta previa, PPROM, membranes bulging in vagina if preterm, etc.).

**General rule:** can use muco on the speculum if you just need to look down below. If you are contemplating checking for pooling/ferning, DO NOT USE MUCO as it will potentially interfere with the ferning test.

**PV Exam:** Almost all patients with cramping need a PV exam to complete the assessment (exceptions: placenta/vasa previa; PPROM not contracting, etc.). Again, at first this exam should be done with a Resident or a nurse until your skills improve. If the patient is <37wks, a Resident should be with you under all circumstances. The following information should be included:

\_\_\_cm \_\_\_% effaced \_\_\_ post/mid/ant \_\_\_vx/breech  
\_\_\_soft/firm \_\_\_station

**Fetal Heart Tracing (FHT):** This should be included in the Physical Exam section as this is the only way we have to assess the fetus. You should get into the habit to comment on the tracing for every patient. This includes:

- (a) baseline HR (normal 120-160)
- (b) variability (normal, decreased, increased)
- (c) accels (present or absent)
- (d) decels (early, late, variables or absent)
- (e) contractions (are there any on the monitor? How often? How strong?)
- (f) Interpretation of the tracing: Reactive or Non-reactive if patient is not in labour (basically an NST); Reassuring or Non-reassuring if the patient is having contractions

**Investigations:** This should include any relevant lab investigations. Remember that triage is not the Internal Medicine service...we do not order unnecessary lab tests "just because". If the test will not change your management, then do not order it. Lab tests include general tests that most triage patients should have done and specific tests for different conditions.

Urine dipstick: almost all patients should have this done even if there is no specific urinary complaint. Pregnant patients are prone to bacteruria. This often will manifest itself as "lower abdominal cramping". Also a good test if you are worried about dehydration in a patient with N+V (ketones) or proteinuria in a patient with high BP.

UA+/-MSU: consider if dipstick is very positive; if you suspect renal stones (looking for RBCs, etc); if you suspect pyelo/UTI; if you want to check proteinuria

CBC: only consider if concerned about significant bleeding, fever, etc.

PIH labs: This is the shortcut to writing out: CBC, lytes, Urea, creatinine, liver enzymes, uric acid, INR/PTT, fibrinogen. Should be done for all patients with high BP or symptoms suggestive of PIH.

Liver enzymes/lipase: consider if patient complains of RUQ/epigastric pain with normal BP (r/o cholelithiasis, cholecystitis, pancreatitis, etc.)

Type and screen/ Group and match: Consider if patient has significant bleeding or potential for bleeding (previa, PPH, very low Hgb, etc)

Others: at your discretion

**Impression:** This is your chance to shine. Include your overall impression of the patient's condition and include your differential diagnosis.

**Plan:** Devise an appropriate management plan for the patient. Be sure to discuss the case with a Resident first if you are unsure of your assessment. All patients must be discussed with the appropriate Attending Staff prior to sending the patient home or admitting to hospital.

**Example:**

27 yo G2P0 at 37 weeks gestation Rh- GBS-  
Known gestational hypertension on labetalol

Reports feeling "wet" in her underwear when she woke up this morning at 8am. Some mucousy discharge associated with it. No odour. No gush of fluid experienced. No continuous leaking. No bleeding. No cramping/contractions. Good FM. No fever or chills. No abdominal/back pain. No dysuria. No diarrhea. Denies headache, visual changes, RUQ pain. Small amount of swelling to ankles worse after prolonged standing.

BP control has been good. Last FAU this week (no concerns). No other complications in the pregnancy.

PobHx: SA in 2001

PMHx: Healthy

Meds: labetalol 200 mg po BID; vitamins

Allergies: Penicillin (rash)

O/E: BP 137/75 HR 75 Temp 36.7

Abdo: gravid uterus, SFH 36 cm. Cephalic presentation. Non tender. No CVA tenderness.

Sterile Spec: No pooling, no ferning, negative nitrazine test. Normal discharge seen. Cervix appears thick and closed.

PV: closed, thick, posterior, firm, vertex, head high

FHT: baseline 130 bpm, good variability, accels present, no decels. No contractions seen. Reactive tracing.

Labs: Urine dip: -'ve for protein, ketones, glucose

**Impression:** 27 yo G2P0 at 37 weeks with a Hx of well-controlled gestational HTN on labetalol presents with ?SROM. No evidence of SROM or active labour seen. Likely normal discharge as seen on speculum exam.

**Plan:** D/C home. Return if gush of fluid, contractions, bleeding or decreased FM. Patient to see her Ob tomorrow as planned. Patient discussed with Dr. Smith on call.

### The Basic C/S Post-Operative Note

If you have been through your Surgery rotation, you may be familiar with the format of this type of progress note. If not, then use the following as a guide to assessing the post-op patients when you're on-call.

The assessment should be fairly brief and focused. The "SOAP" format may be useful.

#### Basic areas of focus:

- Pain control, type of analgesia being used
- Voiding and passing flatus/BM
- Ambulation
- Tolerating diet
- General symptoms: chest pain, dyspnea, dizziness, weakness, calf pain, etc
- Any baby concerns (breastfeeding, etc.)

#### Physical exam:

- Vital signs (found in the chart under the Postpartum Care Map section)
- Abdominal exam to assess for tenderness, distension, etc. and to assess the wound
- Respiratory exam
- Any other examination specific to additional complaints raised by the patient

#### For example:

##### 27 yo POD#2 C/S for cephalopelvic disproportion

**S:** Well today. No concerns. Foley catheter out. Patient voiding well. Passing flatus but no BM. Ambulating well without symptoms. Pain well controlled on Tylenol #3 and Naprosen. Breastfeeding. Slight nausea last night that resolved with Gravol. No CP or SOB.

**O:** BP 134/73 HR 76 Temp 36.9  
Abdo: good BS; soft; mild periincisional tenderness; incision dry and intact

Resp: Clear to bases. No crackles.

**A:** Stable POD#2  
(Pre-op Hgb 117→ Post-op Hgb 98)

#### Plan:

- Start Ferrous gluconate 300 mg po TID
- Possible discharge home tomorrow?

### The Basic Delivery Note

The delivery note needs to convey the basic events surrounding the delivery. In general terms, this should include information about the following:

- Mode of delivery? (SVD, C/S or operative vaginal delivery)
- What was delivered? (either a live/stillborn male or female)
- What do we know about the infant? (Apgars, birth weight)
- How was the placenta delivered and was it intact?
- What is the status of the perineum? (lacerations are graded from 1<sup>st</sup> to fourth degree)
- Were there any complications? (eg. shoulder dystocia, nuchal cord, PPH, etc.)
- Estimated blood loss (EBL)

For example:

SVD live female with Apgars 8<sup>1</sup>, 9<sup>5</sup>  
BW 3657g

Nuchal cord x 1 --> delivered through

Placenta delivered by gentle cord traction and intact  
2<sup>nd</sup> degree laceration --> repaired with 0-Chromic

No other complications

EBL < 500cc

M. Student (M3)

### Call Groups

#### Boyd Group

Dr. Awadalla  
Dr. Best  
Dr. Collister  
Dr. Sabeski  
Dr. Seager  
Dr. Taylor

#### McCarthy Group

Dr. McCarthy  
Dr. Hooper  
Dr. Burym  
Dr. Robinson  
Dr. Ring

#### On call for Self

Dr. Helewa (also takes call with Boyd Group sometimes)

### Important Phone #'s

3A	237- 2767
3B	237-2762/2763
Obs Triage	237-2913
High Risk L&D	237-2778
LDRP	237-3112
Paging	237-2053
<b>Kim Zeller (Program Coordinator)</b>	<b>787-1988</b>